Future looks bleak for new MDs as practice limitations become national issue

Lynne Sears Williams

Windows of opportunity are slamming shut for interns and residents as provincial governments seek to slash health care spending, creating the possibility that medicine will witness its first generation of unemployed Canadian MDs.

Measures ranging from limits on access to billing numbers to fee disincentives are causing panic among new physicians, the acting president of the Canadian Association of Internes and Residents (CAIR) says. "[They have] made a lot of people angry, a lot of people were crying and sad," says Dr. Lisa Moore. "And there's a tremendous amount of bewilderment."

The new austerity was illustrated eloquently as new family physicians prepared to write their national certifying examination, and were informed that Ontario residents in psychiatry, pediatrics and family medicine will be paid 75% less than established colleagues if they locate in that province's overserviced areas. Moore says that announcement, part of an Ontario initiative to trim $400 million from the health care budget, stunned young physicians. More than 250 new family physicians had expected to qualify to enter practice there after June 30.

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"You can only imagine how ill those residents felt as they went to write their exams," says Moore; many residents had already signed contracts and taken out loans to buy practices. Ontario's proposed differential fee, which Ontario Medical Association (OMA) president Dr. Michael Thoburn calls a tragedy, effectively shuts new doctors out of the system.

News is bleak elsewhere too. In New Brunswick, interns and residents are looking with dismay at a government plan to control access to billing numbers through a hospital regionalization scheme. New numbers are available only in underserviced areas. The New Brunswick plan, which specifies government buyouts of retiring physicians' practices and linkage of billing numbers for job sharing, will strictly limit job opportunities for new physicians. The government says disincentive schemes that were in place failed to move new graduates to underserviced areas. It does not plan to allow a two-tier system of private and public practice to develop; doctors without hospital privileges and billing numbers will not be permitted to use provincial hospitals.

In Alberta, Dr. Eric Wasylenko, chairman of an Alberta Medical Association (AMA) task force on physician human resources, says it is clear the province will have to act quickly to develop a policy on the growth in the number of physicians (see sidebar). On May 28, the AMA board decided to ask the province to implement an immediate freeze on the issuance of billing numbers until a master plan is developed. A request from Alberta residents to have the proposal apply only to out-of-province graduates was rejected. The residents are responding with an aggressive public relations campaign that focuses on possible shortages of doctors in rural and inner-city areas.

And residents have noted ominous rumblings in Nova Scotia, where a government-appointed task force wants to hold physician growth to 2% annually.

Résumé : Les internes et les résidents en médecine se sentent trahis, et ils sont irrités par la décision des gouvernements provinciaux d'éliminer des dépenses de soins de santé en restreignant la facturation et en créant des facteurs de dissuasion relatifs aux honoraires. Cette année, les restrictions toucheront directement les nouveaux médecins ontariens qui craignent qu'on leur retire la possibilité d'exercer la médecine. Feront-ils partie de la première génération canadienne de médecins au chômage?

"Many of us are beginning to feel we don't want to stay here anyway."

Dr. Michele Knox

The national picture causes despair for many interns and residents, says Dr. Michele Knox, president of the Professional Association of Residents and Internes — Maritime Provinces. She says new physicians fear they will be permanently shut out of practice in Canada or forced to work in unmanageable situations. "Government has still not addressed why people aren't going to outlying regions," Knox says. She believes the New Brunswick government's plans to provide 2 weeks' vacation and continuing medical education leave for doctors in outlying areas won't ease the pressure new doctors face when providing primary care without sufficient support.

"In some regions you can expect to do one-in-two call, or even one-in-one call," she says. "Nobody else works 24 hours a day, 7 days a week. Why should anyone expect a new doctor to want to do it?"

Knox says that although New Brunswick's plans aren't supposed to take effect until July 1, 1993, new doctors are already being turned away when they inquire about practising in urban centres.

"New Brunswick is so tight it's almost impenetrable," she says. "The government says the targeted number of doctors has been reached — period."

David Balmain, executive director of the New Brunswick Medical Society, concedes that residents have correctly identified many flaws in the regionalization plan. "From our point of view a plan was definitely needed," he says. "We have difficulty with certain aspects of it and our hope is that these deficiencies will be addressed over time."

Balmain says the proposal is heavy on disincentives and weak on incentives, particularly when it comes to retaining rural recruits. Professional isolation is a major reason why doctors leave remote communities and "it is going to be our task to see that the feeling of isolation is reduced. But in the end we can't make rural New Brunswick urban."

Another difficult change for NB doctors will be new rules that outlaw the "willing" of practices to newcomers. "If the area is considered to be overserviced . . . in the long term there will be no option for replacing that retiring physician," Balmain explains. "The only way a physician can be replaced one-for-one is in an area that is considered [underserviced]. Based on our experience with the last 25 years of medicare, it's a drastic change."

Knox, an ophthalmology resident, says the regionalization plan leaves new doctors out in the cold. "We're the ones who are ultimately going to have to work within the plan," she says, "but many of us are beginning to feel we don't want to stay here anyway."

She fears a cascade effect as other provinces take steps to prevent an influx of unemployed New Brunswick and Ontario doctors: "When one province does something, the next province feels it needs to do something as well."

Ontario's proposal to designate alleged areas of overservice

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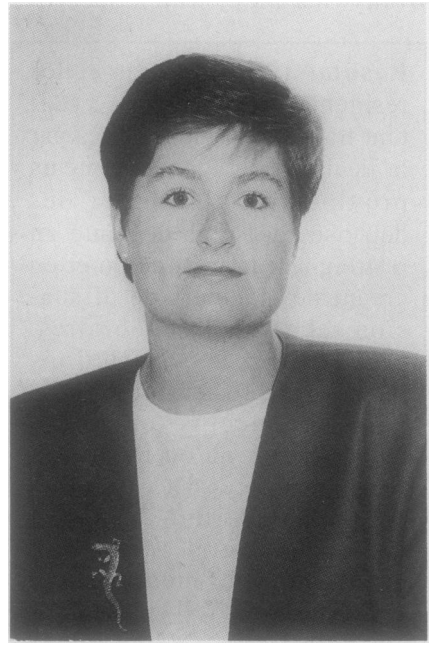

met with rage and disbelief. The original document describing it was also weak — it failed to consider numerous job openings in Northern Ontario. Layne Verbeek, a spokesperson for the Ontario Ministry of Health, says the number of practice opportunities fluctuates and the ministry does not know precisely how many openings there are; it estimates that there are up to 45 in southern Ontario and between 60 and 70 in the north. Verbeek says the ministry is "firm on having an effective differential fee. I don't think the percentage is carved in stone, but a 90% differential fee, for instance, won't be effective."

He says doctor-to-patient ratios in urban Ontario suggest that there is a doctor–patient ratio of 1:350. The ministry expects the harsh differential fee will move surplus physicians to areas that need them. "We are admitting the very real possibility that there will be unemployed physicians," he says. "In future, physicians are not going to be guaranteed a job — we want to stop the open-ended system. I know the personal investment in time is longer for physicians than most other professions, but at this point our backs are somewhat against the wall. Changes have to be made to control health care costs. Sweetening the water hasn't worked, so now it's a matter of souring the water. If there's a criticism to be made, perhaps it is that these measures weren't taken sooner."

Thoburn disputes the government's theory that urban Ontario

"If we don't take care of new physicians, the government will take care of them"

Physician restrictions that have been in force in Quebec for more than 10 years have produced mixed results, the director of communications for the province's Federation of General Practitioners says.

A rural–urban fee differential imposed by the province in 1982 initially met with great resistance, says Dr. Georges Boileau, but passions have cooled over time, mainly because the plan has been largely successful.

The scheme, which specifies that new doctors be paid 70% of scheduled fees for 3 years if they practise in the teaching zones of Montreal, Quebec City and Sherbrooke, and 115% of fees if they practise in remote regions, has helped even out the province's distribution of doctors.

"The major drawback has been that general practitioners have decided not to work in hospitals or emergency clinics because these are the places where the burden of care is greatest," says Boileau. "This has created a shortage of physicians in emergency rooms."

A proposal from the government would address this problem by rescheduling benefits to 100% for emergency physicians in the

Boileau: ceilings are a huge disincentive

teaching zones, starting Sept. 1. However, a controversial new policy affecting doctors with less than 10 years' experience will limit physicians' wages to 70% of scheduled benefits if they fail to contribute 12 hours a week to areas of specified medical need.

"It is [designed] to maintain services at basic levels," Boileau says, adding that the government is working with medical associations to ensure practice opportunities for new doctors. He says medical school enrolment has been carefully monitored in an attempt to limit the number of graduates. "It is not a good thing to have a surplus of doctors," he says. "It is very expensive for society."

Boileau says Quebec's health ministry and doctors' associations have tried to maintain a cooperative atmosphere, and the government has generally consulted with stakeholders, including residents and medical students, before creating new rules. "In 1976 we negotiated salary ceilings and were criticized all across the country for doing it," he recalls. "We didn't want to have them imposed on us, because government [actions], most of the time, are very radical."

The current ceiling on GP earnings in Quebec is $48 513 per quarter, or $194 052 annually. Payments are reduced by 75% for billings higher than that. (Ontario has proposed an annual limit of $250 000.) Boileau says the ceiling is a huge disincentive.

"On the other hand, when a doctor works that much, maybe he should work a little less," Boileau notes. "This would delay his heart attack by 4 or 5 years, probably save his family some stress, and allow new doctors who arrive on the market to have enough work. Otherwise, if as a profession we don't take care of new physicians, the government will take care of them."

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has too many doctors, and argues that the adoption of restrictive policies to control numbers is ineffective. "Forcing people to go to certain areas against their will is a disastrous situation and I think that was the single biggest lesson everyone learned when BC restricted billing numbers" in the 1980s, says Thoburn. "Not only was it very draconian, it simply didn't work."

The OMA president, who agrees that management of physician numbers has become crucial for both medical associations and governments, says physician human resources "is an incredibly complex subject" but "the cost implications of not managing physician resources are simply unacceptable."

Thoburn says the OMA was working with the health ministry on various means to reduce spending, and had successfully managed to slash costs in the last year. The abrupt government announcement has brought the dialogue to an end. "I think that's why we're all rather horrified by this sudden, out-of-the-blue [announcement] — that's not physician resource control."

Thoburn is worried that the disincentives will spark a further flow of new graduates and veteran physicians from the province. "We're already experiencing a terrible exodus . . . and have lost a lot of world-class medical talent. It's a horrifying and unrecognized problem."

Whatever happens, he says, the OMA is not likely to follow the lead of British Columbia doctors, who last summer staged a series of rotating walkouts. "Doctors here don't want to strike, they want to practise medicine," he says. "That's all we want to do. We think it's the government's responsibility to fund necessary care, or stand up and have the intellectual honesty to say they can't do it."

"We will not shoulder a disproportionate burden of the changes being made."

—Dr. Lisa Moore

In Nova Scotia, the Task Force on Physician Policy acknowledges that the balancing of physician numbers takes time. "We have been made very aware of the time lag in effecting change," says Ron Smith, who chairs the committee. "For example, a decision to reduce medical school enrolment would not bring results until 1998."

Among other things, the task force has supported the use of alternative practitioners to deliver care, and the creation of specific hospital regions. It also says the training system should produce a 50-50 mix of family physicians and specialists. Dorothy Grant, communications officer for the Medical Society of Nova Scotia, says the new directives worry both residents and medical students. She expects her son, currently in the fourth year of a neurology residency, will be affected by the restrictive climate that is emerging. "I wonder whether I will have a neurologist son driving a taxi," she says.

Moore says Ontario medical residents won't accept the huge fee differential, which would apply to new doctors for 5 years. "We will not shoulder a dispropor-

Physician, regulate thyself

The Alberta Medical Association (AMA) has appointed a task force in an effort to find out how many physicians are too many. Dr. Eric Wasylenko, chairman of the Task Force on Physician Resources, says changes limiting the number of physicians in other provinces are sparking concerns that Alberta may have to deal with an influx of doctors.

"If other jurisdictions are not allowing free access to positions for new graduates or for other people moving into their provinces, then there will be increased pressure on jurisdictions that don't have any limits," says Wasylenko. "Alberta will be one of those."

Concern that a growing number of physicians would quickly use up the province's global cap for medicare billing prompted the AMA decision to analyse the physician-resources issue. "We want to study this and decide if we have enough doctors," he says. "Do we need more? Do we need to distribute them better in terms of location, or in terms of specialists versus general practitioners?"

Wasylenko says the capped health care budget does not take into account the impact of new physicians entering the system from outside the province. He says the task force will seek opinions from patients and key stakeholders as it creates recommendations. "Is it important for us to stay free and accessible to all?" he asks. "Or should we, as a defensive position, try to control the numbers?"

Dr. Padraic Carr, president of the Professional Association of Internes and Residents of Alberta (PAIRA), says the overservicing issue must be assessed carefully. PAIRA considers restrictions undesirable. "In some areas physician management may have to be re-evaluated, although I think anyone in the general public doesn't think Alberta is overdoctored. It can be very difficult for many patients to make appointments, especially in some specialties."

Carr, a psychiatry resident, says restrictions on physician numbers will limit Albertans' ability to find physicians suitable to their needs. "Restrictions will limit accessibility — any restrictions on [physician numbers] mean restrictions on patients as well. The other concern is that they are going to bar new graduates from practising and there are a lot of benefits from having new doctors in the field."

Carr says new graduates are better trained in cost-saving measures and cost effectiveness. "Additionally, the proportion of women and visible minorities training in medicine is higher now than it's ever been and you're going to cut a lot of those people out of the system."

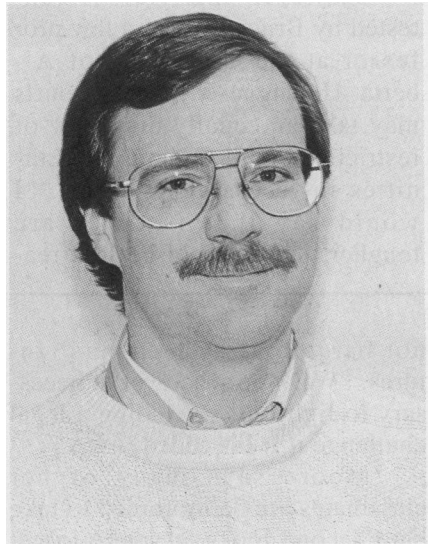
But Wasylenko says medical groups are exhibiting global concern about the number of physicians. "Economists have been saying for years that the costs of the medical system are directly proportional to the number of physicians. Whether I do or don't agree with that evaluation, it's something that needs to be looked at. If the government buys into that theory, it certainly won't want us having an unlimited supply of physicians.

"We're under a lot more pressure now because of what's happening in Ontario, New Brunswick and other provinces. I suspect all the health ministries are looking at this issue. It makes it clear that we have to think about this and do it quickly."

Wasylenko says Alberta has a duty to protect established doctors and new graduates, but he wants to work cooperatively with government. "We should be able to find some reasonable win-win solutions, but obviously not everybody will be completely happy."

He adds: "There's no point in training bright young people and then casting them adrift."

Wasylenko says one objective of recent changes to the Medical Council of Canada's national exam was to ensure portability between provinces, portability that is disappearing as provinces make new rules that prohibit movement. "This is surprising and somewhat unfortunate," he says.



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Is it legal to reduce practice opportunities for new MDs?

Will initiatives to restrict physician employment in New Brunswick and Ontario survive a legal challenge? Several years ago, a British Columbia attempt to address the problem of physician oversupply by limiting access to billing numbers was ruled unconstitutional by the province's Supreme Court. It ruled that interfering with freedom of movement for purposes of employment within a province was a violation of guarantees contained in the Canadian Charter of Rights and Freedoms. In doing so, the court overturned a billing scheme that directed newcomers away from cities to outlying rural regions.

What has changed in the ensuing years to make governments try again to limit access, whether by controlling hospital privileges or by instituting differential fees? Dr. Padraic Carr, president of the Professional Association of Internes and Residents of Alberta, argues that such moves discriminate against the large number of women and visible-minority physicians now being trained by medical schools.

However, an Alberta Crown prosecutor argues that "courts have been pretty clear that the right to liberty does not include an economic right to earn a living.

"In Ontario, for instance, the courts could say the residents aren't being denied the right to move around, they're being denied the right to earn a living, and that's an economic right that's not protected so far.

"The real question is whether they'll be seen as reasonable limits."

—Chris Levy

"Doctors are not private industry," adds the prosecutor, who requested anonymity. "They get paid by government and therefore if government has less money, there is a strong argument that it's a reasonable limit for government to impose."

The fact that the initiatives would adversely affect women and visible-minority physicians might be overlooked by the courts. "The government would argue that the discrimination was not intended. The economic-reality argument is likely to be the government's strongest pitch."

However, this view is contested by Bruce Elman, a law professor at the University of Alberta. He suggests that the courts may take an equally dim view of restrictions on economic opportunities in recessionary times. "I would say that if times are tougher, there would be less reason to limit [access to employment]. If times are tough, why keep people out of the market?

"I would assume that the government is not there to guarantee [established physicians] a certain standard of living. It's there to guarantee reasonable access to medical care. There may be all sorts of reasons for limiting [access] that have to do with the quality of care but I wouldn't think that these have anything to do with the quality of the doctors' lifestyle.

"The real issue would be whether there is some impediment to someone's mobility rights in the country and the British Columbia court said there was," Elman said. "It doesn't sound like things have changed that much."

And Chris Levy, a law professor at the University of Calgary, says the plans being considered in New Brunswick and Ontario would be held to violate the charter. "The real question," he says, "is whether they'll be seen as reasonable limits.

"A lot will depend on how far the courts are impressed with the economic need to control costs," Levy notes. "But it may be less legitimate for the government to try and control costs on the backs of under-represented minorities. There would have to be a lot of fairly detailed social-science statistics to substantiate that. Obviously, the demographics of graduates of medical school will be critical."

tionate burden of the changes being made," she says. "If there's going to be a differential, then it has to affect everyone equitably. We will not be sold out to protect those at the top."

She says CAIR will negotiate with the government, but it will not bargain away members' futures. "We'll do whatever is necessary to fight this, including a legal challenge if it is needed."

Moore says many of her classmates are being forced to take hard second looks at where to get a job, and some are seriously considering a move to the US. "What a waste," she adds. "The system has allowed so many people to train, and we've spent 10 to 17 years training to practise in our own country. And at the end, we're locked out. We are absolutely going to fight it." ■